Connecticut State Dental Association

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The Connecticut State Dental Association (CSDA), on behalf of Connecticut dentists would like to thank the Connecticut Health Insurance Exchange for inviting us to comment on the Mercer final report. As oral health practitioners we recognize that good oral health is integral to overall health. In fact numerous recent scientific studies have indicated that there are associations between oral health and a variety of general health conditions- including diabetes and heart disease. It is important that any plan considered by the Exchange offer a dental component to it.

According to the National Association of Dental Plans (NADP), about 98% of Americans with dental coverage have a dental benefit policy separate from their medical policy. Dental benefits have more predictable costs and vary significantly from medical insurance, which is necessary to insure against catastrophic loss. About 80% of dentists are general practitioners, while the opposite is true for medicine. The disciplines use different procedure coding systems and dentistry has not widely adopted a diagnostic coding system. Therefore we strongly suggest that the Exchange Board establish a dental subcommittee composed of dental carriers, the CSDA, and other stakeholders in the state to provide recommendations on dental coverage issues, including establishing the oral health essential benefit package and which state mandates are included in that package, ensuring adequate provider networks, and maximizing plan transparency and competition and consumer protections.

With regards to the essential health benefits as discussed in Task 4f of the Mercer Report- Feasibility of a Basic Health Program, and Task 4g of the Mercer Report- the Cost of Connecticut Benefit Mandates That Are above the Federal Essential Benefit in the Context of a Revised Insurance Market, we would like to offer the following suggestions. The typical employer-sponsored dental/oral health plan coverage should contain the following:

- Preventive and diagnostic services- 100% coverage (not subject to deductibles)
- Basic restorative services- 80% coverage (subject to deductible)
- Major restorative services- 50% coverage (subject to deductible)
- Orthodontics- 100% coverage for medically necessary treatment, including cleft palate and other similar craniofacial anomalies

As the pediatric oral health benefit is being designed, it is important to ensure that every child will be able to access needed services to address a health condition when medical and dental care are both clinically required. There are health care situations that exist where an underlying medical condition may necessitate a dental intervention and there must be coordination between the medical and dental plans to ensure that these kids don't "fall through the cracks." This situation has caused problems in the past as both medical and dental plans question whether and how the dental service and the anesthesia needed to perform the service are covered. Additionally, children born with birth defects may require additional services that necessitate coordination

between medicine and dentistry. In these situations necessitating both dental and medical services, the key issue is ensuring proper coordination between the coverage provided by medical and dental plans, and clarity about which services are covered by the respective plans to avoid coverage denials by both plans.

It is also suggested that the state mandate Sec. 38a-491a. Sec. 38a-517a. Dental coverage - Inpatient, outpatient, and one-day dental services be included in the new medical plans. This mandate addresses the medical needs of special needs patients, and medically compromised patients that cannot safety be treated in the office setting."

Ensuring adequate access concerns not only the benefit package but also whether appropriate payment structures and mechanisms are in place for administering dental benefits. Additionally, the Exchange would want to ensure network adequacy. It is important that all plans offer an adequate provider network to make the exchange an attractive alternative for consumers. Plans should be required to make information about their networks readily available to providers and the viability of the network should be regularly tested. Networks should allow all dentists willing to accept the terms of the contract to participate in the network. Also, carriers must be required to offer dentists a separate agreement for plans offered within the exchange to enable a full and fair review by the practitioners.

Also important is to ensure a wide selection of proven, market-tested dental insurance products such as dental indemnity, direct reimbursement, and DPPO plans in the Exchange which will benefit consumers and help ensure the long term viability of the health benefit exchange. The traditional dental indemnity plan and direct reimbursement (benefits are based on a percentage of a specified dollar amount up to an annual maximum) offer the consumer maximum freedom. Indemnity plans captured 13% of the 2009 market, according to the NADP. Dental PPOs (DPPOs) are the most common types of plans available to consumers. The NADP estimates that in 2009 nearly 70% of dental plan offerings were provided through DPPOs. By contrast DHMOs had only about 8% of the 2009 dental benefit market, according to the NADP. Furthermore, these plans are on a steady downward trajectory- falling from 15% of the market in 2002.

Consumers would greatly benefit if they had the option of purchasing dental coverage without annual benefit levels and plans with lower copayments. Universally and for many decades, dental benefit plans have had relatively paltry annual benefit limits of $1,000 to $2,000 which are quickly exceeded with one major restorative service. In addition, the copayments for some extensive restorative services are beyond the means of too many individuals. Carriers that offer standard family dental benefits in the exchange should also be required to offer dental plans without annual limits and lower copayments as an option for consumers.

According to the NADP, child-only policies are rarely offered in the private market. Oral health experts know children are more likely to access dental services if their parents have coverage. All participating plans offering a dental benefit should be required to offer family dental coverage as an option.

A wide selection of plans with good oral health benefits and payment structures will be of little value unless the consumer fully appreciates the cost and benefit of the various plans. Dental benefits offered by medical plans and stand-alone dental plans in the Exchange should allow for “apples-to-apples” comparisons so that consumers can easily understand their choices based on price, quality and other factors, such as provider network adequacy. All medical plans in the Exchange offering an “embedded” children’s essential dental benefit must also be required to offer a very similar medical policy without the dental coverage so that consumers have more real coverage choices. To help the consumer understand how much of the premium cost is attributable to the dental component of the medical plans the cost of the embedded dental coverage should be clearly stated.

Individuals who purchase oral health benefits through the Exchange deserve equal access to consumer protections irrespective of the plan (medical or dental or some combination) used to purchase the dental coverage. Reporting standards, use of plain language in the coverage explanation, cost-sharing information disclosure and past performance of the plan have been identified as important transparency measures. An adequate network and an appeals process that permits an external review are also important.

Regarding Task 10 of the Mercer Report- Impact of the PPACA on Connecticut Medicaid and CHIP Programs and the Interaction with Exchange Plans, we would point out that the Medicaid (EPSDT) and CHIP benefit packages promise a great deal but they often fail to provide adequate access to services due to shortcomings in the way that the benefit is financed and/or administered. The payment structure matters as much as the benefit. In general terms, state dental programs that use a managed care capitation payment system are not successful. On the other hand, state programs that utilize a dental benefits manager to administer the benefit have had greater success because the managers have expertise working with the dental delivery system. Finally, to significantly improve the likelihood that plans will be able to offer adequate networks of dentists, common sense rules should apply, including that a plan's fee schedule will not apply to non-covered services and that carriers be required to make prompt payment of claims.

As the Connecticut Health Insurance Exchange proceeds with its work we would again offer any expertise that you may require in order to ensure that the citizens of Connecticut have the highest quality and most affordable oral health care available to them as possible.

Sincerely,

Tatiana Barton, DDS
President